The bills have much in common. I hope working together we in this House and our colleagues in the other body can send to the President's desk a Patients' Bill of Rights that will serve patients, doctors and all Americans and maintain the strong system of employer-provided health insurance that has made the American health care system the best there is in the world.

## MANAGED CARE REFORM FROM A DEMOCRATIC PERSPECTIVE

The SPEAKER pro tempore (Mr. KIRK). Under the Speaker's announced policy of January 3, 2001, the gentleman from New Jersey (Mr. PALLONE) is recognized for 60 minutes as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, I intend this evening with some of my colleagues on the Democratic side to focus on the same issue that the previous Republican Members focused on, and, that is, the Patients' Bill of Rights, the HMO reform bill.

I must say that it disturbs me a great deal to see some of the opponents of the real Patients' Bill of Rights, the bill that has been sponsored by the gentleman from Michigan (Mr. DINGELL), who is a Democrat; the gentleman from Iowa (Mr. GANSKE), who is a Republican and a physician; and the gentleman from Georgia (Mr. NORWOOD), who is a Republican and a dentist, and that was voted on overwhelmingly by every Democratic Member of the House of Representatives in the last session and about 68 Republican Members, the real Patients' Bill of Rights, is now being superseded on the other side of the aisle by the Republican leadership which is now promising to bring an alternative bill which they also refer to as the Patients' Bill of Rights to the floor.

I would remind my colleagues that the real Patients' Bill of Rights, the one that we voted on, one that all of us, most Democrats and a significant number of Republicans have been pushing for for probably 5 or 6 years, is the bill that should be allowed to come to the floor rather than the Republican alternative, the Fletcher bill, which is in my opinion nothing but a fig leaf and which does not accomplish the goal of truly reforming HMOs.

There are two essential goals of HMO reform that are in the real Patients' Bill of Rights. One goal is to make sure that medical decisions are made by the physician, the health care professional and the patients, not by the HMOs, not by the insurance companies; and the second goal is to make sure that if you have been denied care by the HMO that you have a legitimate and reasonable way of seeking a redress of grievances and overturning that decision so you can get the care that you need.

I would maintain, and we will show this evening once again, that the Fletcher bill does not accomplish that goal; and the real Patients' Bill of Rights, the Dingell-Ganske-Norwood bill, does.

I wanted to, if I could this evening before I yield to some of my colleagues, really point to the two major criticisms that I heard on the Republican side of the aisle tonight against the real Patients' Bill of Rights. One is that there are going to be too many lawsuits. The second is that it is going to drive up health insurance costs.

The best way to refute that is to refer back to the Texas law that has been on the books for a number of years now which is exactly the same really as the real Patients' Bill of Rights and which shows dramatically that neither one of those disasters, all these lawsuits, all this litigation, or the other disaster that my Republican colleagues talked about, that health care costs are going to be going up, that insurance companies are going to drop their patients, neither one of those disasters befell the State of Texas because a real Patients' Bill of Rights was put into effect.

It is interesting because, in reality, what President Bush is doing in the last few weeks and leading up to hopefully a vote this week on the Patients' Bill of Rights is that President Bush is waving the same flags that he used in the State of Texas when he was Governor to say there is going to be too much litigation and that insurance companies are going to drop patients and not let Americans have health insurance, that they are going to drop health insurance. These were the arguments that the President used when he was the Governor, they are the arguments that he is using now, and it is simply not true.

Mr. Speaker, if I could just give some statistics. This goes back to 1997 when then Governor Bush said of the Texas law and I quote, ''I'm concerned that this legislation has the potential to drive up health care costs and increase the number of lawsuits against doctors and other health care providers.'' What did the President, then Governor do? He vetoed a bill similar to the Patients' Bill of Rights in 1994.

In 1997, when it came up again, he did everything he could to sabotage the bill to the point that he actually refused to sign it but I guess for political reasons figured that he could not veto it again and so he simply let it become law without his signature. But we are getting the same rhetoric again.

Last week as the Patients' Bill of Rights, the real one, made its way towards debate in the House, the President said almost the same thing; and I quote. He said, ''This is how best to improve the quality of care without unnecessarily running up the cost of medicine, without encouraging more lawsuits which would eventually cause people not to be able to have health insurance.''

Again, that people are going to have their health insurance dropped, that litigation is going to increase.

Let us look at the facts. Since the 1997 Texas law that Bush opposed so strongly has taken hold, the disastrous effects he had predicted have yet to occur in the Lone Star State. In the 4 years since, even the law's opponents acknowledge that none of then Governor Bush's predictions have come true. Instead of becoming a bonanza for all these trial lawyers, the right to sue an HMO or an insurance company in Texas has been exercised just 17 times. In all the years since 1997 that it has become law, only 17 lawsuits. That is an average of three or four per year.

According to the Texas Department of Insurance, the number of Texans enrolled in health insurance or HMO plans has actually increased steadily since the 1997 law was passed. Enrollment has grown from 2,945,000 Texans at the end of 1996 before the law was passed to 3.2 million at the end of 1997 to 3.9 million at the end of 2000. There is just no truth to this. In fact, when you talk about the cost, the cost of HMO premiums in Texas have risen but less than the national average. So the bottom line is the disaster has not occurred.

I know I almost hesitated to talk about what is happening in Texas because my two colleagues whom I know are going to join me tonight are both from Texas and I do not like to speak about another State, but it is all positive. The experience has been totally positive.

How can the President or any of our Republican colleagues on the other side of the aisle suggest the same kind of thing, the same kind of disaster that is going to befall the Nation when Texas has been such a success story?

Just to give an example, one of the reasons, of course, and I always maintain that what the HMO reform would do and what the Patients' Bill of Rights would do was essentially correct the errors of the system. Because once the HMOs know that they cannot get away with these things, then they start taking corrective action and making sure that patients get the type of care that they want. Because they know that if they deny care there is going to be an external review by independent people outside the HMO, or they know that ultimately people can go to court. So they correct the situation. It becomes preventative. That is essentially what the Patients' Bill of Rights will do.

Again, the Texas situation points that out very dramatically. In Texas, you could go straight to the courts if you want to, but people overwhelmingly go to the independent review. This is an external review, a group of people that review a denial of care that are not appointed by the HMO and not influenced by the HMO.

From November, 1997, through May, 2001, independent review doctors have considered 1,349 complaints in Texas. In 672 of these assessments, or 50 percent, they overturned the HMO or the insurance company's original ruling, I guess in about half the cases. What we are seeing is now that patients know that they can go outside the HMO and

have an independent review of a denial of care. They are exercising that. They are not going to court because nobody wants to go to court and have litigation and spend money and go on and on for years. Nobody wants to do that, not the patients any more than the HMOs or the insurance companies.

What they set forth in Texas is a very easy way to review denial of care. It has been largely successful. The bottom line is there is absolutely no reason why we should not try to implement it on the national level.

Some people have said to me, well, if the States are doing this, why do we need the national law?

First of all, not every State is doing it. Texas has probably the best law. None of the others are as good. Most States still do not have anything near the protection that Texas offers.

In addition to that, because of a statute called the Employee Retirement Income Security Act, or ERISA, those people who are insured through employers who are self-insured, and I do not want to get into all the bureaucracy of that, but that is about 60 percent of the people who are insured in this country, they are not subject to the State laws. You need the national law like the Patients' Bill of Rights to make sure that they have the same kind of protections that they would get in States like Texas if they were covered by the Texas law.

The other thing that really upsets me, and I have to be honest about the Fletcher bill, the Republican alternative that we heard about earlier this evening, is that it would preempt the State law. Experts in Texas will tell you that if the Fletcher bill, the one that my Republican colleagues were talking about tonight, were to become law, it would supersede the Texas law and we could have a situation where the very people that are being protected by that law now and have that independent review or the ability to go to court might not have that kind of protection because the Federal law, the Fletcher bill, would preempt it.

What is happening down here? Mr. Speaker, my colleagues might say, are we ever going to get to this Patients' Bill of Rights? Are we ever going to get to HMO reform? Is it even going to come up in this House? The leadership on the Republican side have said that they are going to post the bill this week. What bill? We do not know. Are they going to give us a clean vote on the real Patients' Bill of Rights, the Dingell-Norwood-Ganske bill? Or are they just going to let us consider the Fletcher bill, which is a weak alternative? Are they going to give us the chance to consider any bill? I would suggest that there is a serious question of that.

What is happening right now, from what I understand, and I am just reading some news clips as well as what I hear, the scuttlebutt around the floor here in the House of Representatives is that the votes are not there for the Fletcher bill. In other words, almost every Democrat is going to vote for the real Patients' Bill of Rights and a good percentage of the Republicans are going to do it, also, as they did last session. The votes are not there to pass the weak alternative, the Fletcher bill that my Republican colleagues were talking about earlier this evening.

So what is going to happen is that we hear the President is coming back tomorrow from Europe and that he is going to spend the rest of Tuesday, Wednesday, maybe Thursday trying to twist arms to convince Republicans who supported the real Patients' Bill of Rights last year to not support it this year and vote for the weaker Fletcher bill. Then if that does not happen and there are not enough votes, then we are not going to have an opportunity to vote on the Patients' Bill of Rights this year.

That is not fair. I know that Democrats are in the minority here in the House of Representatives. Republicans control the agenda, and they can bring up whatever they want. But the bottom line is that we know that there is a majority for the real Patients' Bill of Rights, for the Norwood-Dingell-Ganske bill that is made up of almost every Democrat and enough Republicans to create a majority. We have a right, given that that majority exists, to have that bill come up for a clean vote this week. I will say right now to the Speaker and to my colleagues that if that right is denied us because the Republican leadership realizes that there are enough votes to pass the real Patients' Bill of Rights and not enough to kill it with the Fletcher alternative, there is going to be a lot of recriminations around here because we do not have the right to vote on that bill.

So I would say to the Republican leadership, bring up the Patients' Bill of Rights. You want us to vote on the Fletcher bill? The votes will not be there. Bring it up. Then let us vote on the real Patients' Bill of Rights, the Dingell-Ganske-Norwood bill.

□ 2045

But either way, let us have a clean vote this week, because that was the commitment that the Republican leadership and the Speaker made, and they should fulfill that commitment this week and let us vote on the patients' bill of rights on HMO reform.

Mr. Speaker, I would like to yield now to one of my two colleagues from Texas, both of whom have been here on a regular basis with me speaking out on this issue, and I particularly like to see the two of them tonight, because I know of their experience with the Texas law and their involvement in the health care issue and the HMO issue for so many years as Members of our Health Care Task Force. I yield to the gentlewoman from Texas.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I thank the distinguished gentleman from New Jersey. I am delighted to be able to join him, along with my distinguished colleague, the gentleman from Texas (Mr. RODRIGUEZ), who has served in the State legislature and serves, as I do, on the Energy Brain Trust of the Congressional Black Caucus. He, of course, leads the leadership of the health issues with the Hispanic caucus. We know that these are global American issues, and so we come to speak to them as they are global issues.

I was fascinated by the debate of my colleagues that occurred just a few short minutes ago regarding the pending debate as relates to now new legislation, H.R. 2315, now known as the Fletcher bill. I was quite fascinated because one of the strongest elements of the Ganske-Dingell-Norwood bill and the McCain bill is the bipartisanship and the age of the bills. These bills have been vetted throughout the country, they have been vetted by Members of both sides of the aisle, and they have been seen to be logical and direct responses to the needs of American people.

I am very disappointed that the administration, with the leadership of President Bush, that comes directly out of the State of Texas, who has seen a bill similar to the Ganske-Dingell-Norwood bill work, would now throw this curve, so that we could not do this for the entire citizenry of America.

There is a study that exists, and I cannot quote the particular survey that was done, but it was recently done out of Fort Worth, that shows in the time frame of the passage of the State bill that is very similar to what we are debating and hopefully will debate, the real patients' bill of rights, shows that there have been less than 30 cases dealing with challenges to HMOs, lawsuits, if you will, and all of them have been non-frivolous and they have been based upon the negligence of the HMO in denying medical care.

Let me just refer to you my thought processes here on the Fletcher bill. First of all, it now becomes a potpourri, a kitchen sink, of private savings accounts for health care and a myriad of other tax issues and accounting issues, and this is not what the American people are asking for.

The basic underlying principles of the Ganske-Dingell-Norwood bill, and we could put it in any other framework, the bill passed in the Senate, the McCain bill, is about accountability. The simple basic premise is not frivolous lawsuits, it is not harassment, it is not intimidation, it is simply to hold HMOs accountable for negligence. It is not even holding them accountable for their existence. There are many viewpoints about HMOs, but we have seen that many of the holders of HMOs, the individuals who have health plans, like their individual health plan.

This is not an uprising by the American people to randomly throw out health plans without cause. The bottom line of why we thought it was necessary some 3 or 4 years ago, as the gentleman from New Jersey is well

aware of, to come to the aid of the American people, were the egregious denials that were occurring to various holders of health care or managed care programs and plans throughout the Nation.

Right now I can remember the lady that was flown from Hawaii because she was denied service, and, as she got off the plane in Chicago, she died. I remember the very moving and stirring presence of, I think, a multiple amputee, of a little boy about 8 to 12 years old, that the gentleman from Iowa (Mr. GANSKE) brought to the floor of the House to educate us about a young boy who was denied emergency care, and, because of that, suffered multiple amputation of his limbs. We are talking about egregious circumstances that have to be addressed.

Interestingly enough, we are still holding the American Medical Association, the premier group that knows about medical care in today's hospitals and today's rural and urban communities, who have indicated their strong and committed support of the legislation of the real patients' bill of rights.

Let me cite to you a direct quote from the American Medical Association. It says, ''June 28, 2001, the American Medical Association called on Congress to reject the HMO lobby's desperate smokescreen that the McCain bill,'' which is, on the House side, the Dingell-Ganske-Norwood bill, ''would increase the number of uninsured. In the nine states that have comprehensive patients' rights laws in place, there have been very few lawsuits, and the laws have not caused premiums or the number of uninsured to skyrocket.''

This goes to the very point dealing with the fact that employers, well-meaning employers, good-intentioned employers, will be the ones that will suffer. First of all, I know we are looking to address that question, but primarily that kind of result is not the result, did not happen in Texas, and certainly we cannot expect it to happen, as evidenced by the statement of the American Medical Association, which has assessed the nine states that have this bill. We have not seen evidence of skyrocketing costs, uninsured individuals skyrocketing, and employers running away from their employees in providing health insurance.

Let me cite you an additional point. Last year, without a patients' bill of rights to blame, insurers nationwide, no patients' bill of rights existed, increased premiums by an average of 8.3 percent. That is ten times what it would cost for the liability provisions in the McCain bill, and, again, that is the House bill as well that we have, and the number of uninsured went down.

That is by Dr. Reardon, the President of the American Medical Association. I think what we need to do is to present to the American people the facts, and, if we present to them the facts, they will adhere to the reasoning of why we have come to their aid.

For example, we know that HMOs, or managed care entities, have found as the basis for their existence the controlling of hospital admissions, diagnostics tests or specialty referrals, either through programs to review the use of services, or by giving participating physicians a financial stake in the cost of the services they order.

Here lies the angst of the American people. What the American people have been used to and have asked for us to remedy for them is the ability to pay for health insurance plans and to be able to access those plans. What we have had over the last couple of years without a patients' bill of rights is hard-working Americans being denied access to emergency care, access to specialty care, and, in women in particular, access to Ob-Gyn care and being able to select them as our primary care.

As you can see, I was so struck by the earlier debate, forgive me for utilizing all these facts, but I believe that we have worked so long, I am recalling hearings that we had, where people came from across the country to share with us some of the terrible examples, stories, anecdotes, personal experiences, where they were denied care, not by their physician who encouraged the care, but by an HMO, and, as we have noted before, HMOs that are using various computers and nonmedical personnel, plugging in to the computer and sending back the message to Houston, Texas, or to Orange, New Jersey, if you will, or Newark, New Jersey, or San Antonio, or Chicago, Illinois, that the service will be denied.

This is what is not provided in the Fletcher bill. It does not guarantee, according to the American Medical Association, access to pediatric specialists. Now, my State and many States have huge medical centers. We are very proud of the Texas Children's Hospital. We see patients from around the country. My district is next door to that facility. But it is world-renowned.

In that hospital there is a great need for specialists. When children come from around the world, they come there because they have been referred. But in many instances when they are sent back to their home destinations, those doctors wanted to refer them to specialists to continue their care. The Fletcher bill does not guarantee access to pediatric specialists.

Tell me one parent that wants to accept the kind of health care that does not allow them to secure the best specialty services for their child? Juvenile diabetes, which we know is a terrible devastating disease, how many want to be referred back to their home community and cannot access a pediatric specialist?

The Fletcher bill fails to guarantee referrals to specialists for patients with congenital conditions, and obviously I am very gratified for the research and technology that has allowed us to live longer with congenital disorders. We cannot do so, however, if we leave the large medical institutions that we have maybe in the large cities, go back to our respective communities, and cannot be referred to specialists.

It does not allow women to see gynecologists without asking permission from the HMO. When should that become a specialist, such that you have to require affirmation or confirmation on what is necessary care for women on an ordinary daily basis? As we well know, preventative care is the key.

Let me conclude by adding this: it does not guarantee that a specialist be geographically accessible or the specialist be appropriate for the medical condition of the patient. I mean, if you are suffering from pancreatic cancer, which, of course, is enormously deadly, and they want to send you to an internist who focuses on general medical conditions, that does not relate to the seriousness and the devastating impact of your disease.

In addition, the Fletcher bill contains numerous loopholes in the point of service option which severely limit the ability of patients to buy coverage that allows visits to out-of-the-network providers. What that simply says is I have got a long-standing relationship with my physician, and many of us who grew up with our pediatrician and grew up with doctors who visited our homes or grew up with the family practitioner, we know when we join HMOs plans, to our chagrin, the network prevented us from going back to those physicians who knew our family history, who had cared for us; and, I tell you, senior citizens in my district have been painfully impacted by not being able to have their long-standing physicians, as well as they have been painfully impacted by the Medicare HMOs who canceled out because it has not been profitable for them.

So this whole idea now of a substitute, and let me attribute to my colleagues good intentions; let me attribute to those who have offered H.R. 2315 good intentions. But I can assure you that as they have offered these good intentions, what really is happening are smoke and mirrors.

I said I was concluding, but if the gentleman would just bear with me for just a moment, and I will conclude to just simply say some additional points that are just glaring and frightening.

If you take H.R. 2315 and you want to look at what is happening to the Senate bill and the House bill, listen to all of the ''no's'' on the side of the Fletcher bill. Requires coverage for minimum hospital stay for breast cancer treatment, no; prohibits discrimination based on genetic information, no; requires choice of primary care providers, no; prohibits provider incentive plans; no; requires prompt payment of claims, no; protection for patient advocacy, no. In the course of the McCain bill and the House bill, you have ''yes'' to all those necessities that are part of our efforts.

I would simply say to the House and to the leadership, give us the opportunity to have a full debate on the

McCain bill, on the Ganske-Dingell-Norwood bill, and for those of us who have experienced a personal crisis with our loved ones, as I have done in the last 3 to 4 years, with a loved one and a parent, where I had to press the point of the kind of specialty care that would have extended his life. Unfortunately, I lost him.

□ 2100

Unfortunately, I lost him. Many of us have seen the loss of our dear relatives. I would say that there is nothing more personal and more privileged than good health care. I would hope that our colleagues would see the error of their ways and begin to open the doors in the next 48 hours for us to be able to debate the real Patients' Bill of Rights, what America has asked for, and that we can carry on the truth serum, if you will, the good medicine, and get this legislation passed.

Mr. Speaker, I yield to the gentleman from New Jersey.

Mr. PALLONE. Mr. Speaker, I want to thank the gentlewoman from Texas for bringing out all of the really good points that she did in effectively refuting most of the points that the Republicans who support the Fletcher bill, the weaker bill, if you will, the points that they made this evening.

But there were two areas that I would like to focus on before I yield to the gentleman from Texas (Mr. RODRIGUEZ) that I think the gentlewoman really brought out and that I did not bring out, and one is that I focused a lot, and I think that the Republicans on the other side focus a lot, on the liability issue, the question of whether one can sue or not sue. I think to some extent, in refuting them, I kind of fall into the trap of discussing the liability issue.

The fact of the matter is, and the gentlewoman pointed it out very effectively, that part of the problem or a major problem with the Republican alternative, with the Fletcher bill, is that it does not provide the patient protections that the real Patients' Bill of Rights that we advocate provides. The gentlewoman pointed out a number of them, but just to mention a few others: The Fletcher bill fails to protect the patient-doctor relationship. It leaves out two things with regard to the patient-doctor relationship that we have in the real Patients' Bill of Rights.

First of all, we have the gag rule that says that the doctors can freely communicate with their patients and the HMO cannot tell the doctor that if it is their procedure or some type of care that is not covered that they cannot tell the patient that it is available. It is called the gag rule. Well, the Fletcher bill does not protect against the gag rule. The HMOs could still tell the physicians that they cannot talk about a type of care that is not covered, which is a horrendous thing. I mean, people would not believe that a doctor could be gagged in that way.

Secondly, the Fletcher bill does not protect against using these improper incentive arrangements where the doctor gets paid more if he provides less care or does not provide as much care, depending on the procedure, he gets paid a little more. That is not protected in the Fletcher bill.

The other thing, and the gentlewoman went into this, so I will not go into it too much, but basically the Fletcher bill has a lot of flaws in the area of access to specialty, clinical care and clinical trials.

The other thing I will mention briefly before I yield to the gentleman from Texas is the poison pills. One of the ways that the Republican leadership succeeded in the last session in killing the real Patients' Bill of Rights, as the gentlewoman knows, and we all know that it passed here in the House, the Ganske-Dingell-Norwood bill passed and almost every Democrat and 68 Republicans, I believe, voted for it. But when it got to conference, what they did is, they kept arguing, if you will, over these poison pills. In other words, it passed in the House, but it had these poison pills with regard to the medical savings accounts and the malpractice suits.

The Fletcher bill has two poison pills like this. It expands the medical savings accounts and also the association health plans. I do not want to spend time tonight getting into all of those, but the bottom line is they have absolutely nothing to do with the Patients' Bill of Rights or patient protection. They have to do with the way they save money and deal with your health insurance and what kind of health insurance pools we have. They do not belong in this bill. If we pass that bill, we will have the same thing again in conference where they try to argue those issues and they manage to kill the real Patients' Bill of Rights.

Again, we need a clean bill. That is what we are asking for, the real Patients' Bill of Rights, the clean bill that only deals with HMO patient protection and does not mess things up with all of these poison pills. I am glad the gentlewoman brought that up, because it is another criticism of this Fletcher Republican alternative.

Ms. JACKSON-LEE of Texas. Mr. Speaker, if the gentleman will yield, I appreciate him reinforcing that point. Because as I was reading through some of my materials, the poison pills are so damaging because they are contrary to the American people.

Two points: Over 80 percent of the American people believe that HMOs should be held accountable for negligence. They are not asking about Federal savings accounts and other issues. They also believe they should be able to get to emergency rooms in the 80 percent range. It does not seem like they are focusing on all of this other baggage that the Fletcher bill has.

Before the gentleman yields, and I thank the gentleman from Texas for allowing me to make this point, as I was coming to the floor and hearing the debate that preceded us, there was some comment about minorities and how this would have a negative impact on minorities. We know that African Americans, Hispanics, Asians, whatever group we want to classify as minorities come at all economic levels. Certainly, many of us in the minority community, African American community, particularly Hispanic community, Asian community, carry HMO coverage and many do not. They need to access either public assistance or they need other sorts of assistance, or we are trying to work with their employers so that they can have the kind of coverage that they should have. But I think that it is certainly misrepresenting to suggest that this bill will hurt minorities.

Mr. Speaker, I want to reinforce that this bill will give all Americans a Patients' Bill of Rights to reestablish the patient-physician relationship and help individuals who are unable to fight the system by being able to hold HMOs accountable. So if one happens to be the bus driver, the waitress, the schoolteacher, the accountant, the doctor, the lawyer, one can still have the ability to hold the HMO accountable for negligence when they have denied you the care that you have paid for. I cannot see any way that this will hurt minorities.

In fact, for those minorities who we well know have a disparate access to health care, whose health has been impacted because they cannot get good health care, to make HMOs more accountable and ensuring that when a physician calls from an inner city needing added care for that particular victim or patient, I should not say victim but patient, that that physician can access that health care, regardless of whether they are in the inner city of Harlem or Houston or anyplace else that might relegate them to inadequate health care.

So I refute that, and I question any comment suggesting that this bill would hurt minorities and, in particular, let me say, African Americans, and I cannot find any evidence in this bill where that would occur.

I thank the gentleman.

Mr. PALLONE. Mr. Speaker, I thank the gentlewoman for bringing that up, because I think essentially what our bill does is empower people. It does not matter who one is, one's race, one's color. The bottom line is people who are sick are not easily empowered. They are victims, even though we do not want to use that term. What it does is it empowers people at a time when they really need help, regardless of their race, religion or whatever, and that is what we are all about.

I thank the gentlewoman.

Mr. Speaker, I yield to the gentleman from Texas (Mr. RODRIGUEZ).

Mr. RODRIGUEZ. Mr. Speaker, I thank the gentleman for allowing me to be here. I also had a chance to listen to the dialogue that was coming, and I

have the hour after yours regarding border health, but I needed to come up here because, in all honesty, there was a sense of frustration and some anger. Because, as the gentleman well knows, for the last two or 3 years we have been talking about making sure we pass a Patients' Bill of Rights. We know that people are, throughout the country, having those difficulties. Not only do they have to fight their illness when they get sick, but they have to fight their HMO and their managed care system, and that is unfortunate.

One of the good things about it is, if nothing else, now they are talking about it. Now they have brought up the issue. Now they realize that it is something that is serious and so they need to at least begin to give it lip service. But we are hoping that they do more than just lip service, because I know that they can do that and then decide not to do what they are supposed to be doing.

Mr. Speaker, I cannot help but recall an incident back when I was in the State legislature when we talked about access to rural health care. One of the first things we talked about was how can we get access to rural Texas. At that time, when I was in the Texas legislature. I remember that a person with any logic, any sense of wanting to really respond to the problem, would start thinking, well, let us see how we can get a doctor down there. Let us see how we can get a mobile unit down there. Let us see how we can get some nurses down there.

Well, the response from what actually occurred after all that, because I was real naive to the political process, was they decided to draft legislation that was tort reform. So here we stand and what I hear is the lawyers are going to get it. I am not a lawyer. I do not care about attorneys. The only thing I do care about is to make sure that those people have access to health care. Yes, in some of those critical situations, if HMOs are not responsive, they should have access to the judicial courts. No one who is sick would want to go to the courts. No one who has been hurting and is tired enough of having to fight their HMO wants to go see an attorney. I know I would not want to do that. But one has to be able to leave that as a last option, no matter what.

I will share an example. I have a friend who was working in the garage, cut his finger, his finger fell off completely, and he got scared, grabbed it, and he went to the hospital. He went into the emergency room. This happened prior to the legislation. First, they had some trouble getting the doctor that he should have been seeing, and then the specialist, they had trouble getting the specialist. Well, the insurance company, the bottom line was, told him, number one, we are not going to pay for that specialist because we did not okay it. So here he is, losing a finger, and he has to try to get an okay as to whether this specialist should put it on or not. Well, he lost his finger. He does not have the finger now. They are still unwilling to pay, approximately, a little less than $3,000. What does he do? What does he do?

So one of the things that this particular legislation does is it allows an opportunity for the person to choose the doctor of their choice, and that is so important. Not only is that critical, but it also allows that physician to determine whether one needs a specialist or not. Those are the ones that are supposed to be making the decisions, not the accountant, not the insurance based on how much profits they are going to be making or not making if they make certain decisions. It should be made on the needs of that person.

Secondly, the bill covers all Americans, and that is so important, whether one works for small businesses or not. There are company doctors that are out there that we need to be concerned about. A lot of times the company doctors will choose to make decisions based on the needs of the company and not the particular patient. So that becomes real important.

Thirdly, it ensures that all external reviews of medical decisions are conducted by independent, qualified physicians, and that is so important. We want to make sure, if you are there, if your mother is there or if a loved one is there, you want qualified people making those decisions. You do not want them to be made because they are going to save a few hundred dollars or a few thousand dollars in choosing not to do certain procedures.

The other thing is that doctors right now, and the gentleman mentioned this, are gagged by the gag rule. They are actually being told that they cannot provide certain options where they can tell the patient, look, you have this disease, these are the options. You can do this, this, or this other option and then decide. The cost varies. They are not even allowed to do that.

We ought to be ashamed of ourselves. We have passed this piece of legislation several times already, and the Republican-dominated Congress continues to kill it in conference. Now, they get up here, and now they are talking about it.

Well, let us see if it does not turn into a situation where the rules will allow a lot of other amendments to come in and then, very similar to what happened in campaign finance, where they allowed so much junk out there so that they were going to pile it up so that not even the author would want to be able to vote for that piece of legislation.

So I am hoping that, as we move forward now, that at least we got them to a point that they are at least talking about it, and that we can go forward in making sure that we do the right thing when it comes to the Patients' Bill of Rights, when it comes to our patients throughout this country.

I want to thank the gentleman for his hard work that he has done, because he has been at the frontline. We need to keep hitting on this issue. It is something that is right, and it is something that we need to do.

I just want to remind the gentleman that President Bush, then Governor Bush, initially vetoed the first Patients' Bill of Rights in Texas.

□ 2115

The second time, and that was in 1998 when it came back, then at that point he allowed it to go through, although he had the same arguments then of that bill that he has now. That is, his arguments against the bill were that it would increase costs and increase the number of lawsuits against doctors. That has not occurred. That has not happened. He also mentioned that other health providers would also be hurt by it. That has not occurred.

It has been a good piece of legislation. It still has some holes that need to be worked out, but I think that we could do this, and it would go a long way throughout this country to providing those people who have insurance right now and who get sick at least that leverage to be able to fight the disease and not have to fight the managed care system, so that the managed care system becomes more accountable to our constituency throughout this country.

Mr. PALLONE. I want to thank my colleague from Texas. I know that my other colleague wants to add something too, so I yield got to the gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Mr. Speaker, I would just inquire of the gentleman about an example, or I guess it is not an example when one loses a finger. I think the gentleman has just highlighted a very potent part of what this debate is about: human beings. The gentleman's friend lost a finger because someone made a medical decision.

I cannot for the life of me understand why we cannot have commonality, common ground on supporting the gentleman's friend or that patient's ability to be able to have the best health care that any plan could provide or any services in the United States could provide.

My question is, we seem to have fallen victim to special interests, because we have the American Medical Association physicians from all walks of life who simply want to be able to treat that patient whose finger was amputated through a work injury, or to treat a child suffering from a congenital heart defect or juvenile diabetes, or treat someone who is suffering from pancreatic cancer, which is devastating.

What we do not want is to have that person be told, ''There is no room at the inn. The door is closed. You cannot get services.''

I would say to the gentleman, this gentleman's friend seems to be suffering from an entity, a corporate structure, or an institutional structure

that was not really concerned about his health care. What we are trying to do with the Patients' Bill of Rights is to put the patient and doctor back together again.

Mr. PALLONE. Mr. Speaker, if I could just say to the gentlewoman, she is getting to the point that I wanted to raise by our colleague from Texas.

He talked about lip service, and what has been happening here with our Republican colleagues on the other side tonight is that they realize now that the Patients' Bill of Rights has the support overwhelmingly of the American people.

As the gentlewoman said, the special interests have been out there, the HMOs, the insurance companies, fighting this thing tooth and nail. Even with all of that, look at all of the recognized groups that care about patients, and the AMA being probably the most prominent, but there are so many other supportive groups, the nurses and all the specialty care doctors, too.

Our colleague, the gentleman from Connecticut, mentioned one specialty care, but I could rattle off every specialty care diplomate organization in the country that is supportive of the Dingell-Ganske-Norwood bill.

What they are doing now is paying lip service to the issue because they know it is an issue that is strong and that people want because it affects real people, like the guy who lost his finger.

What I wanted to say if I could, and then I will yield back, is that we have to be very careful what we do here. These people that oppose the Patients' Bill of Rights, the special interests, they are pretty sophisticated. What they are trying to do tonight with this Fletcher bill is suggest that somehow this is not that different from the Dingell-Norwood-Ganske bill.

It is not true. It is simply not true, because we have to remember that that person who is in extremis, the person who lost their finger, they are very vulnerable individuals. If we are going to make sure that the decision about what type of care they get is made by the doctor, and that if that is denied that they have a real way to redress the grievances, we could make some very simple changes in the law and eliminate both of those things.

That is what they have done with the Fletcher bill, because one of the things we have in the real Patients' Bill of Rights is to say that the standard of review about what kind of care is necessary, what the physician should be allowed to provide, is decided by the physicians, by the standard of care within the medical community, and particularly within those specialties, the pediatric standard, the cardiological standard for the specialty care, or the general standard for family practice care.

They have basically said in their bill, in the Fletcher bill, that that review process is going to be different. It is going to be stacked against the patient.

I will just give an example. The bill, basically what it says is the standard review used by the external review process requires the reviewer to make its decisions on only the patient's record and scientific evidence, and does not allow them to get to the standard of care that exists within the larger community or that exists for that specialty.

I probably sound like a bureaucrat in relating all this, but the bottom line is, we make sure that the decision about what medical care is necessary is the standard that the AMA would use, that the cardiologists' Board of Diplomates would use. They are not using that standard. The guarantee that that decision is going to be based on what the physician thinks is necessary is denied by the Fletcher bill.

The other thing is that we have a rapid ability to overturn a denial of care, in our bill. What the Fletcher bill does is to put all kinds of barriers in the way, so that guy who lost his finger, he cannot easily say, I have been denied care and I can go to somebody, and they right away turn around that decision, so he can get his finger reattached in a timely fashion. They put all kinds of barriers in his way.

I will just give an example. In the Ganske-Dingell-Norwood bill, we require the decisions are made with regard to the medical exigencies of the patient's case. This means the plan has to act quickly when needed.

There is no such requirement in the Fletcher bill. There is nothing that says, my finger is detached. If they are denying me care, I have to have somebody who is going to within minutes change that decision over the phone. That is not the case. They could say under the Fletcher bill that one would have to wait a few days, a couple of weeks. How does that work with a guy who loses his finger?

I will give one more example, but there are ten that I could give here.

The patient, under the Ganske-Dingell-Norwood bill, it requires that patients have a right to appeal to an external reviewer before the plan terminates care. That is not true in the Fletcher bill. So to use the example with the guy who lost his finger, they can continue to provide him all kinds of care, but maybe not what is necessary to reattach the finger. He cannot go to the board and have the decision turned around while they are continuing to treat him in some maybe not effective way.

So there are all kinds of ways to get around the basic protections that we are providing in the Ganske-Norwood bill. The problem with the Fletcher bill, it is using all kinds of little ways to get around that. We do not have time to go into it all tonight, but I want there to be a basic understanding that there is a real difference here between these two bills.

As the gentlewoman said, my colleague from Texas, they are giving lip service to the Patients' Bill of Rights, but they are not really for the real Patients' Bill of Rights.

I yield back to the gentleman from Texas (Mr. RODRIGUEZ.)

Mr. RODRIGUEZ. Mr. Speaker, I would hope that when people provide lip service, I would hope that we judge people on what they also do. So when they give it lip service, I am hoping they will go beyond that and start acting in an appropriate manner.

But when we talked about rural health care, they came up with tort reform. If they use it for political reasons to get after and reward their friends and do in their enemies, then that really upsets me and angers me. I saw the tones of that when they got up here.

The majority of people do not like attorneys. I am not one, and I do not know if the gentleman is one. I apologize if the gentleman is. But the bottom line is that we have the judiciary for a reason. Those judges, I respect the judges out there, with the exception of the Supreme Court in the last decision that they made. Beyond that, most judges do the right thing. We would expect that people would go only to the judiciary in the last resort.

With our piece of legislation, it allows a review board, and it allows that review board to be able to look at that data before any court decision. So it would be very obvious to anyone if something wrongful had occurred. And if it does occur, and if it occurs with one's loved one or anyone, then that person deserves to receive justice if they were denied access to a certain care that caused them injury.

So I think that is important, and that ultimate right still belongs to every American. It should not be taken away by the insurance companies of this country. Just because they have paid insurance all their lives, and all of a sudden they are sick and find themselves not having access to the quality care they had been paying for and had been promised, and they find themselves once again fighting the disease and the illness and also fighting the HMOs, then they would wonder, where are our politicians? Where are they?

We have been trying to make this happen, and I hope that they are sincere about trying to make something happen and make people accountable, and make those insurance companies accountable for doing the right thing when those people find themselves in need.

Mr. PALLONE. I appreciate the gentleman's comments. I yield to the gentlewoman from Texas (Ms. JACKSON-LEE), Mr. Speaker.

Ms. JACKSON-LEE of Texas. Mr. Speaker, the gentleman made a slight comment as he was describing the Fletcher bill procedure, and he said he was sounding like a bureaucrat. No, the gentleman was explaining the bureaucracy that the Fletcher bill was now going to recreate to inhibit the direct review or direct opportunity to hold HMOs accountable.

Fingers do not last long that are detached, and emergency surgery or

needs for immediate care cannot tolerate scientific review and paperwork review and computer review and standards review. They can tolerate a trained specialist or physician looking at the facts with the patient before them, consulting with their colleagues and making an immediate decision to save this person's life.

What I see is a pitiful response to the outcry of Americans about care and the relationship between physicians and patients. It is creating this whole new established bureaucracy that does nothing but delay the decision. If I have to get my child into an emergency room circumstance with a pediatric specialist at hand and if that is denied me, then I may shorten the opportunity for my child to recuperate.

We have seen some tragic incidences occurring with children just this summer. When the summertime comes, we know that children engage in fun, but we also know it opens them up to various incidents that occur. They need immediate health care.

I would say to the gentleman, no, he is not the bureaucrat, but the Fletcher bill would certainly create a whole new independent set of bureaucracies that do not get care to the patient. I just think that we should come together in this House and the Senate and vote for the real Patients' Bill of Rights.

Mr. PALLONE. I want to thank the gentlewoman, and both of my colleagues from Texas.

I think we only have another minute or so. I wanted to say that my real concern, of course, is that we never get a chance to vote on the Patients' Bill of Rights this week or even this year. We know that the leadership, the Republican leadership, has promised that the bill will come up for a vote this week.

We are going to hold them to the fire on that, that it must come up and that we must have a clear vote, a clean vote on the real Patients' Bill of Rights. We will be here every night, if necessary, this week to make that point until that opportunity occurs.

## BORDER HEALTH

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2001, the gentleman from Texas (Mr. RODRIGUEZ) is recognized for 60 minutes.

Mr. RODRIGUEZ. Mr. Speaker, I was just here talking about the Patients' Bill of Rights and how important that issue is. I want to take this opportunity tonight to begin to talk a little bit about border health.

Mr. Speaker, I rise today to call attention to the poor state of health along the U.S.-Mexican border. The United States-Mexico border reaches approximately 2,000 miles, from the Pacific Ocean in the West to the Gulf of Mexico in the East.

More than half of this border, over 1,248 miles, is shared with Texas. It is a vast region, and each of the four southwestern border States have a unique history and community dynamics.

However, Texas, California, Arizona, and New Mexico's borders all share the plague of persistent socioeconomic problems largely ignored by the rest of the Nation.

□ 2130

If the United States border region of Texas were declared the 51st State, and we say this and we kind of talk in Texas about the fact that we are one of the few States that has a law that says we can divide our State into five States if we wanted to, but if we were to make the 51st State on the border of Texas, taking those counties into consideration, it would rank as one of the poorest in terms of access to health care, second in the death rate from hepatitis, and third in the death rate of diabetes. The rate of the uninsured is among the highest in the country, as are the poverty rates.

In Texas and New Mexico, an estimated 30 percent of the border residents have no health insurance, and in Arizona it is estimated at 28 percent, and the estimates in California are 19 percent. So that what we have throughout the border area is a very large lack of access to health care.

I am relieved that there is finally a focus on health care and this has dominated both of the campaigns in the previous elections. There is some talk about the importance of border health now, although this focus had not been there before. Since the focus has started now and some dialogue has started, we are hoping to be able to get revenues to the border.

I strongly support all the efforts that have been made to pass a comprehensive Patients' Bill of Rights, and we are going to continue to move forward on that, but I urge my colleagues to also look at the issues of access and especially in underserved communities such as the border.

Oftentimes, the emergency rooms end up being the first line of care for residents in underserved areas like the border. It is also true that health disparities along the border are enormous. For those of my colleagues who have ever visited the border, any of the areas I represent, Starr and Zapata on the border are the two counties I have of which are in my district, both Starr County and Hidalgo County, not in my district, these two counties included are among the four poorest counties in the Nation. So we have a great deal of poverty associated with lack of access to health care.

The district that I represent faces many health and environmental challenges. The poor state of infrastructure leads to real health and environmental problems, including hepatitis, diabetes and tuberculosis. Health problems are compounded by low per-capita income, lack of insurance, and lack of access to health care facilities.

There is no question that the border region is crying out for increased resources in the face of so many challenges. Tuberculosis has emerged as a serious threat to public health along the border. One-third of the new TB cases in the U.S. were from four southwest border States. Once again, one-third of all the cases in the United States come from the border.

The ease with which an individual can contract the tuberculosis bacteria is often frightening. Often someone needs to do no more than breathe in the tuberculosis bacteria coughed into the air by the infected individual. Currently, 15 million Americans are infected with tuberculosis, which means we are all at risk. So this disease hits some communities more than others.

Regions which have high levels of tourism, international business and immigration experience higher than average levels. For instance, Texas has one of the highest tuberculosis rates in the country now. My State ranks seventh nationwide in the incidence of tuberculosis, with TB rates of 8.2 percent per 100,000. Even more sad is that minorities suffer disproportionately. Latinos in the United States have a tuberculosis rate six times that of Anglos.

Tuberculosis is not the only disease of which the border residents are hit disproportionately. They also suffer from diabetes.

When we look at diabetes, the border has a higher mortality rate than the rest of the country. Again, I will use the Texas statistics. In 1995, the Texas diabetes mortality rate was nearly 50 percent higher than the rest of the United States. Gestational diabetes and Type II diabetes hit the Spanish population in greater numbers than other populations, and it is the Hispanic population that makes up the larger percentage of border residents. It is unacceptable that such a high number of border diabetes patients die from disease that can be controlled and even prevented.

When we consider the effect that environmental pollution has on health, it gets even worse. Last week we debated whether to let Mexican trucks into the United States. I cannot stress again how important it is that these trucks meet U.S. safety standards, especially when it comes to emissions. Our air quality along the border is threatened due to the increased truck traffic brought about through NAFTA. More children than ever are developing respiratory problems, such as asthma, causing them to miss school, extracurricular activities and, even worse, to be hospitalized.

Water pollution poses a serious health hazard, including the spread of Hepatitis A and parasitic infections. Hepatitis A, spread mainly through unclean food and water, is two or three times more prevalent along the Mexican border than the U.S. as a whole. The presence of lead in water can cause damage to developing brains, the nervous system of children, and affects reproductive systems in adults.